82-767

No.

FILED
NOV 8 1982

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1982

DR. NATHANIEL L. WILLIAMS,

Petitioner,

v.

VISION CARE SERVICE, INC.

Respondent.

# PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

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## QUESTION PRESENTED:

Whether it is a violation of the anti-trust laws for a corporation to enter contracts with membership organization to provide vision care services to the members of those organization through independent optometrists setting the maximun price that the member optometrists may charge the member patients, and imposing other restraints that in other industries have been held to be violations of the anti-trust laws?

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| I. The Decision of the Court Below is contrary to the recent decision of this Court in Arizona, Petitioner v. Maricopa County Medical Society, Et. Al., 102 S.Ct. 2466 (1982). In that case it was held that prepaid medical plans are not ipso facto immune from the antitrust laws and that an agreement under which maximum fees were set for doctors was a per se violation of the Sherman Act. | 11 |
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IN THE

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OCTOBER TERM, 1982

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DR. NATHANIEL L. WILLIAMS,

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v.

VISION CARE SERVICE, INC.

Respondent.

---

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

---

Petitioner prays that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the District of Columbia Circuit entered in this case on August 5, 1982.

OPINIONS BELOW

The opinion and order of the United States District Court for the District of

Columbia was rendered on January 19, 1981, and the order was filed on January 30, 1981, granting defendant's motion for summary judgment. The district court did not write an opinion. The judgment of the United States Court of Appeals for the District of Columbia Circuit was entered on June 4, 1982, and the order of the Court of Appeals denying the petition of rehearing and rehearing en banc was entered on August 5, 1982, a copy of the order appears in Appendix a5.

## JURISDICTION

The judgment of the United States Court of Appeals for the District of Columbia Circuit was entered on June 4, 1982, a timely petition for rehaearing and rehearing en banc was filed and an order denying the petition was filed August 5, 1982. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

## STATUTORY PROVISIONS INVOLVED

The pertinent provisions of sections one and three of the Sherman Act, 15 USC §§1,3, and section three of the Clayton Act, 15 USC §14 appear in Appendix a1 hereto.

The respondent, Vision Care Services, Inc., (V.C.S.) is a corporation that was established and is operated by a group of approximately twelve optomertists who practice in the Washington, D.C., Baltimore, Maryland, Central Maryland, and Northern Virginia areas. This corporate entity does not provide any vision care services itself. It enters contracts with organizations that are interested in providing visual care to their members to make visual and optical services available to them through optometrists who have been approved by Vision Care Services, Inc. At the time relevant to this case Vision Care Services, Inc., had contracts with some thirty or more organizations.

In order for a doctor to be approved by Vision Care Services, Inc., he had to agree to abide by certain restraints with respect to the source of his supplies and materials, and with respect to the price he

would charge patients who received care pursuant to their relationship with an organization with whom Vision Care Service had a contract.

Source of Supply

With respect to the source of supply, the contracts between Vision Care Services and the doctors on the approved list provided that (1) all materials must be American made and supplied, (2) all materials used must be invoiced from an optical laboratory approved by Vision Care Services, and (3) only American made frames may be used. To enforce these requirements the contracts provided that "payment will not be made for materials from any other source unless prior authorization is obtained from the Board of Directors of V.C.S.

Price Fixing

The contracts contained four sig-

nificant price fixing restrictions. Two of these related to patients who received services that were encompassed within the scope of Vision Care Services's contract with the contracting organization. The other two applied to services by the doctors to patients who were affiliated with contracting organizations but who were receiving services that were not covered by the program.

With respect to services in the first category, the doctors were not permitted to charge more than the maximum amount set by Vision Care Services for the service. This restriction applied even if the patient were willing to pay the difference between the amount set by Vision Care Services and a higher amount charged by the doctor for the services. The contracts explicitly provided that "the doctors will consider the

payments by V.C.S. as payment in full for all authorized services and will not bill the patient for any part thereof."

An additional price restriction was placed on the doctors based on the price charged other patients. If the maximum allowed by V.C.S. was higher than the usual and customary fee charged to other patients he could not charge more than the usual and customary fee charged to other patients. To enforce this price restriction V.C.S. made investigative inquiries to find out the amount charged other patients.

If the doctors rendered services to patients that were not covered by the V.C.S. program, such as providing sun glasses or other special glasses, the doctors were subject to two price fixing restrictions. (1) The materials (lenses,

frames, etc,) acquired from a laboratory had to be resold to the patient by the doctor at the doctor's cost. (2) The fee charged by the doctor for his services had to be the exact fee set forth on an itemized fee schedule provided by V.C.S.

Other Restraints

Each doctor must warrant to V.C.S. that he is not and will not become a member of "any other group vision care program or similar organization unless specifically authorized by the Board of Directors of V.C.S.

V.C.S. actively sought to prevent the participation of its approved doctors in any other "group vision care program" as per section 8-D of the V.C.S. Doctors' Manual and as set forth in a V.C.S. Quarterly News Letter for January 1976 (see appendix).

All frames as well as all other materials and supplies used by the doctors

on the V.C.S. approved list are explicitly required by the contract to have been made in America.

Between November 7, 1972 and January, 1977, Dr. Williams was on the V.C.S. approved list. Prior to his termination he was subjected to the contractual restraints listed above. Throughout the time he was involved in the program, Dr. Williams lost money due to the imposition of these restrictions. He consistently submitted invoices and was denied payment of the amount charged for his services because V.C.S., based on its investigations felt that the amount charged were more than the usual and customary fee charged to other patients. Dr. Williams also lost money by not being free to use the laboratory of his choice. This hardship continued until for economic reasons he started to use laboratories that were

not approved by V.C.S.

The district court below in granting Vision Care's motion for summary judgment did not make specific findings as to which facts it regarded as not material and in dispute and which it regarded as material an not in dispute. The court gave no indicatiion of its views on the applicable law. The court simply said "the court is of the view that there are no genuine material facts in dispute and the court will grant summary judgment."

## REASONS FOR GRANTING THE WRIT

I. THE DECISION OF THE COURT BELOW IS CONTRARY TO THE RECENT DECISION OF THIS COURT IN ARIZONA, PETITIONER v. MARICOPA COUNTY MEDICAL SOCIETY ET AL., 102 S. Ct. 2466 (1982). IN THAT CASE IT WAS HELD THAT PREPAID MEDICAL PLANS ARE ARE NOT IPSO FACTO IMMUNE FROM THE ANTITRUST LAWS AND THAT AN AGREEMENT UNDER WHICH MAXIMUM FEES WERE SET FOR DOCTORS WAS A PER SE VIOLATION OF THE SHERMAN ACT.

The facts of this case clearly disclose that Vision Care Services is in reality a cartel through which the contracting organizations fix the price of optical services and materials (lenses, frames, etc.) for their members. There are price fixing agreements between V.C.S.

and the contracting organizations with respect to the amount the doctors will be able to charge their patients who are members of their organizations. V.C.S. does not contract to serve patients itself. As a non-profit corporation, it is not a competent professional qualified to provide services to patients. Moreover, the contracting organizations with which it enters the agreements are neither patients nor potential patients. The individual members of the contracting organizations are the patients. It is the individual member of the contracting organizations who in reality ultimately pay for the services they receive from the doctors. Even when they do not do so directly, they do indirectly in the form of organizational dues or by providing their labor in exchange for an employment package where the program is offered as a

"fringe benefit" in partial exchange for their labor.

One test that this Court has applied to determine the relative rela tionship of the parties to a restraint is the risk of loss test. The Court used that test in Simpson v. Union Oil Co. of California, 377 U. S. 13 (1964). In that case, Union Oil Company imposed price restraints on Simpson and other gasoline dealers. In order to attempt to shield the arrangements from the per se rule Union Oil Co. reserved the title to the gas in itself until it was sold to the ultimate consumer. Union Oil Co. entered consignment agreements with the dealers. Under the consignment agreements, Union Oil Co. set the price at which the gas could be

sold, kept "title", to the consigned gas and paid the property tax on the gas possessed by the dealers. The dealers were required to carry personal liability insurance and property damage insurance and were responsible for any loss of the gas in their possession. The dealers were compensated by minimum commissions and paid all costs of operation. The court held the arrangement to be unlawful price fixing in disguise. The dealers bore the real risk of loss. There was no ligitimate reason to reserve title. The court recognized that there are legitimate uses for consignment contracts. However, it pointed out that:

> No matter how lawful it might be as a matter of private contract law it must give way before the federal antitrust policy. Thus, a consignment is not allowed to be used as a cloak to avoid § 3 of the Clayton Act . . . . Nor does § 1 of the Sherman Act tolerate agreements for retail price maintenance.

In the present case, Vision Care Ser-

vices would try to convey the impression that it has created a contractor-subcontractor relationship. However, when the risk of loss test is applied, V.C.S.'s arrangements are clearly revealed as price fixing schemes. The risk of loss for the program was on the doctors, not on V.C.S. V.C.S. withheld 20% of the doctors' fees "for the possible contingency of poor experience on claims utilization." In other words, the risk of a poor business judgment was to be borne by the doctors and not by V.C.S. This money was held for a period of three months after termination of the contract between V.C.S. and the contracting organization, thus providing V.C.S. a sufficient insulation against loss. The doctors were required to carry professional liability insurance, V.C.S. was not.

A good indication of the dominant concern that V.C.S has with pricing is the fact that it places a restriction on the

prices that the doctors can charge for services and materials not related to its program. It requires the doctors to sell their materials at costs and provide their services at the amount set out in the fixed fee schedule established by V.C.S. It is well established by the decisions of this Court that fixed fee schedules even for professionals are unlawful. See, Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975). In the present case it is clear that V.C.S. has no independent interest to protect by the imposition of the restraints in question. Then whose interest is it protecting? The answer is obvious. It is that of the contracting organizations and their members. The restraints are horizontal with a vertical facade.

This Court in an analogous situation applied the "whose benefit test" and held that the ostensible vertical arrangement was really a horizontal restraint with

a vertical facade. United States v. General Motors Corp., 384 U.S. 127 (1966). In this case, General Motors had location clauses in its dealer contracts. One dealer was selling cars through discount lots and selling more cars. General Motors tried to stop him. This Court found that General Motors did not have an interest to protect by the location clauses. It was really enforcing those clauses for the benefit of the dealers. Thus General Motors in that instance was functioning as a cartel for a horizontal restraint, just as V.C.S. is doing in the case presently before this Court.

The program structure in this case is strikingly similar to that which existed in the case of United States v. Sealy, Inc., 388 U.S. 350 (1967). In Sealy, the corporation was established with power to determine the price at which its mem-

bers would sell mattresses. This Court held that the arrangement was a horizontal price fixing agreement and was therefore per se unlawful.

## II. THE GRANT OF SUMMARY JUDGMENT TO THE DEFENDANT IN THIS CASE WAS INCONSISTENT WITH AND INCOMPATIBLE WITH THE PRINCIPLES THAT THIS COURT HAS SET FORTH FOR SUMMARY JUDGMENT IN ANTITRUST CASES.

Even if one were to assess the validity of the restraints imposed by Vision Care Services on Dr. Williams and the other doctors who participated in the program by getting on the approved list in terms of the "rule of reason" rather than the per se rule the defendant still should not have been granted summary judgment. Under the rule of reason there should at least be an inquiry with respect to

power, purpose and effect. It was patently clear in this case that because of the large number of contracting organizations, the large number of doctors (approximately 266) on V.C.S. approved list, and the dollar volume of business effecting commerce that the trade restraints were at least quantitatively substantial. See, Standard Oil of Calif. and Standard Stations, Inc. v. United States, 337 U.S. 293 (1949). Yet there was no evidence relating to the reasonableness of the restraints, the reason for the restraints or any other relevant factors under the rule of reason. This was not done and probably could not have been adequately done on a motion for summary judgment because the consideration and resolution of such matters are suitable for trial and not summary judgment.

This Court has pointed out that sum-

mary judgment motions should be treated cautiously in antitrust cases. In Poller v. Columbia Broadcasting System, 388 U.S. 464 (1962), the leading case on summary judgment in antitrust cases, a summary judgment had been entered favor of the defendant. In doing so this Court stated the following:

> We believe that summary procedures should be used sparingly in complex antitrust litigation where motive and intent play leading roles, the proof is largely in the hands of the alleged conspirators, and hostile witnesses thicken the plot. It is only where the witnesses are present and subject to cross examination that their credibility and the weight to be given their testimony can be appraised. Trial by affidavit is no substitute for trial by jury which so long has been the hallmark of 'even handed justice.' Id. at 473.

Where the legality of conduct turns on such factors as intent, reasonableness and effect, there must be interpretations of complicated and extensive evidence. This can generally be elicited only at trial. As was pointed out in Modern Home Inst. v. Hartford Accident and Indem. Co.,

573 F2d 102, 109 (2nd Cir. 1975) it is a rare case where the evidence available to both sides is fully explored before trial and where the alleged conspirators can establish that the evidence is not susceptible of the inferences.

The effect of granting the defendant's motion for summary judgment in a case such as this is to hold the restraints involved per se lawful. This point can be illustrated by an examination of one of the restraints in this case other than those that have held by this Court to be per se unlawful, such as price fixing.

V.C.S. requires the doctors to agree to buy all their materials, i.e., lenses and frames, etc., only from the laboratories approved by V.C.S. This restriction is in restraint of trade. It clearly has the effect of foreclosing competition in the optical industry, depriving the doctors of

the right to reach professional business decisions and depriving patients of another choice in the market place. The only question is whether a finder of fact would determine such a restraint to be reasonable or unreasonable under the Sherman Act or to have a substantial or an insubstantial effect on commerce under the standard of the Clayton Act. In no event should such a restraint be held ipso facto lawful on a motion for summary judgment. See, White Motor Co. v. United States, 372 U.S. 253, (1963), where this Court held that it was error for the district court to have decided the question of the legality of a group of vertical restraints on a motion for summary judgment. This Court said "we know too little of the actual impact . . . to decide on the bare record of a summary judgment."

Restraints on the source of supply are neither per se lawful nor per se un-

lawful. In each instance the legality must be determined by an evaluation of power, purpose and effect. This cannot be done on a motion for summary judgment. The case of Copper Liquor, Inc. v. Adolph Coors Co., 506 F2d 934 (5th Cir. 1975) was a case where the court rejected the quality control argument asserted in defense of a restraint on dealers. The Adolph Coors Company argued that its territorial limitations were reasonably necessary to provide monitoring to ensure that beer bearing its name was brewed in an "aseptic process rather than pasteurized, was properly refrigerated and that beer even sixty days old was removed from the market." In rejecting this defense the court said: "we think that the present record would not support the conclusion that the ... restrictions are essential to the integrity of (the) pro-

duct and the survival of the firm." Id. 944. A comparison of Clairol, Inc. v. Boston Discount Center, 608 F2d 1114 (6th Cir. 1979) with Clairol, Inc. v. Comsmetic Plus 130 N.J. Super. 81 (1974). In the first cases the court upheld the "safety first" position for the restriction; in the other it rejected it.

In a case such as the present case where there are already governmental standards applicable to the industry, and where the party imposing the restraint has no interest in the product, V.C.S. would have a heavy burden to carry in supporting its vague contention that this restriction is reasonable as applied and used by it. The V.C.S. procedure for the approval of laboratories was simply to request the laboratories to send V.C.S. price lists through the mail. V.C.S. then made its de-

termination based on these lists. V.C.S. does not engage scientists, experts or any one else to ascertain the quality of the materials used by a given laboratory under consideration. V.C.S. does not have anyone to monitor the accuracy of the products produced by any of the laboratories. Based on V.C.S.'s lack of standards it would appears that any laboratory meeting the standards of the Food & Drug administration and the National Bureau of Standards should be allowed to sell their wares to the doctors on the V.C.S. list.

III. THE DECISIONS OF THE LOWER COURT IS IN CONFLICT WITH A LONG LINE OF DECISIONS OF THIS COURT HOLDING THAT GROUP BOYCOTTS AND CONCERTED REFUSAL TO DEAL ARE UNLAWFUL PER SE.

In Klor Inc. v. Broadway-Hale Stores, 359 U.S. 207 (1959) it was pointed out by

this Court that when a group of competitors (two or more) agree not to deal with a person or firm outside the group or to deal only on certain terms, there is a combination in restraint of trade violating section one of the Sherman Act.

In Paramount Famous Lasky Corp. v. United States, 282 U.S. 30 (1930) pointed out that a group boycott--like price fixing--is deemed inherently harmful to the economy and thus cannot be justified.

In this case the V.C.S. imposed restrictions that all the frames, other materials, and supplies used by the participating optometrists had to be American made which automatically meant that certain supplies had to be boycotted by the participating optometrists. Futhermore, the restrictions which prohibited participating optometrists from offering their services to

other "pre-paid vision care programs, automatically means that there is an agreement to boycott and a concerted refusal to deal. Therefore, the aforementioned restrictions in this case should be held to be per se violations of the Sherman Act, in accordance with previous decisions of this Court.

## CONCLUSION

The decisions by the District Court and the Court of Appeals in this case are reminisce of other cases that have had to come before this Court in order for it to reiterate that there is no professional exemption from to the antitrust laws. It appears that when the Court decides the proposition in one professional context, the problem is later presented in another professional context. In the past the Court has performed the task with respect to the medical profession, the the legal profession, and the legal profession, among others. The problem has also been attacked by the Justice Department with respect to professional engineers and certified accountants. The professional exemption concept appears to be like Hydra, a multifarious monster which cannot be overcome by a single effort. Each time this Court cuts it down in one professional con-

text it springs up in another. However, just as Hercules was able to finally slay the evil nine headed monster in Greek mythology by cutting of each head and cauterizing the wound, this Court is called upon to perform a Herculean task, of finally ridding the antitrust field of the professional exemption concept. Therefore, we now ask that this Court reiterate its position in the context of the optometrist profession and cauterizing yet another wound.

For the aforesaid reasons, the Court should grant the petition for writ of certiorari.

DATED: November 3, 1982.

Respectfully submitted,

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## APPENDIX

Section one of the Sherman Act, 15 USC §1, provides in pertinent part:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States or with foreign nations is declared to be illegal.

Section three of the Sherman Act, 15 USC §3 provides in pertinent part:

> Every contract, combination in form of trust or otherwise, or conspiracy, in restraint of trade or commerce in any Territory of the United States or of the District of Columbia, or in restraint of trade or commerce between any such Territory and another, or between any such Territory or Territories and and State of States or the District of Columbia, or with foreign nations, or between the District of Columbia and any State or States or foreign nations, is hereby declared illegal.

Section three of the Clayton Act, 15 USC §14 provides in pertinent part:

> That it shall be unlawful for any person engaged in commerce, in the course of such commerce, to lease or make a sale or contract for sale of goods, wares, merchandise,

machinery, supplies or other commodities, whether patented or unpatented, for use, consumption or resale within the United States or any Territory thereof or the District of Columbia or any insular possession or other place under the jurisdiction of the United States, or fix a price charged therefor, or discount from, or rebate upon, such price, on the condition, agreement or understanding that the lessee or purchaser thereof shall not use or deal in the goods, wares, merchandise, machinery, supplies or other commodities of a competitor or competitors of the lessor or seller, where the effect of such lease, sale or contract for sale or such condition, agreement or understanding may be to substantially lessen competition or tend to create a monopoly in any line of commerce.

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

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No. 81-1760 | September Term, 1981

Dr. Nathaniel F. Williams, : Civil Action No. 79-02721
Appellant,

v. : FILED June 4, 1982

VISION CARE SERVICE, INC. :
Appellee.

Appeal from the United States District Court for the District of Columbia.

Before WRIGHT and MIKVA, Circuit Judges, and Jameson,* Senior District Judge.

JUDGMENT

This cause came on to be heard on the record on appeal from the United States District Court for the District of Columbia and was briefed and argued by counsel. The issues presented have been accorded full considerations by the court; they occasion no need for an opinion. See Local Rule 13(c).

This court is of the view that this appeal should be dismissed, without prejudice to the litigation of appellant's contract claims in the Superior Court of the District of Columbia.

On consideration of the foregoing, it is ORDERED and ADJUDGED by this court that this appeal is dismissed without prejudice.

It is FURTHER ORDERED by the court, sua sponte, that the Clerk shall withhold issuance of the mandate herein until seven days after disposition of any timely petition for rehearing. See Local Rule 14, as amended November 30, 1981.

Per Curiam
For the Court

George A. Fisher
Clerk

*Of the District of Montana, sitting by designation pursuant to 28 U.S.C. §294(d) (1976).

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

---

No. 81-1760 September Term, 1981

Dr. Nathaniel F. Williams, : Civil Action
Appellant, No. 79-02721

v. : FILED

VISION CARE SERVICE, INC. : August 5, 1982
Appellee.

BEFORE: Robinson, Chief Judge, Wright, Tamm, MacKinnon, Wilkey, Wald Mikva, Edwards, Ginsburg and Bork, Circuit Judges

O R D E R

Appellant's suggestion for rehearing en banc has been circulated to the full Court and no member of the Court has requested the taking of a vote thereon. On consideration of the foregoing, it is

ORDERED by the Court en banc that appellant's suggestion is denied.

Per Curiam
For The Court

GEORGE A. FISHER, CLERK

By:
Robert A. Bonner
Chief Duputy Clerk

March 10,1971

This "VCS Doctors' Manual" is an updating and expansion of the "Guidelines for Participating Doctors" which was published on July 1, 1870.

It is the responsibility of each Doctor to be familiar with all provisions of this "Manual" and any error, oversight or deviation from it, without the prior approval of the Board of Trustees of Vision Care Services, Inc., will be considered a violation of the Agreement between the Participating Doctors and V.C.S., Inc. and will be dealt with accordingly. Flagrant violators will be removed from the Panel of Doctors of VCS, should such drastic action be deemed necessary.

If there are any omissions, corrections or questions about this "Manual," please communicate with one of the members of the Board of Trustees. We will issue addenda and changes as needed which

should be kept with this "Manual" on permanent file to serve as a reference text on Vision Care Services.

Board of Trustees
Vision Care Services, Inc.

2/75


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## I. PARTICIPATING DOCTORS

Each Eligible Beneficiary, hereafter called Patient, covered by a Group Contract will receive, included with his Claim Form from the Administrator's office a list of all current Participating Doctors, hereafter called Doctors. This list is revised monthly and the Patient may select a Doctor of his choice. In remote areas where there are no VCS Doctors available, the Patient may select a Doctor from panels of other vision service corporations having an Interchange Agreement with VCS, such as the Optometric Service Corporation of Virginia. The Patient may receive a list of these Doctors upon request to the Administrator. Under such circumstances, the Administrator will process claims from these Doctors and pay in accordance to usual VCS procedures. Doctors may also service patients from other parts of the country whose service corporation has a Reciprocal Agreement, through the Vision Institute of America, with VCS, Inc. For clarification contact one of the Trustees.

## II. CERTIFICATION OF ELIGIBILITY

A Vision Care Certificate of Eligibility (Claim Form) must be presented to the Doctor by each Patient prior to the examination. The name on the form must be the same as the Patient to be examined. If not, contact the Administrator's office immediately. Check the expiration date on the Claim Form. If expired, eligibility may be verified in the same manner. Note any exclusions, special authorizations, or in some Contracts, extra charges to the Patient, on the Claim Form. Have the Patient sign the Claim Form during the

initial visit.

III. BENEFITS

The Benefits vary with the Trust Funds but generally each Patient may receive a Visual Survey or a complete Visual Analysis, if indicated, and one pair of prescription lenses, if needed, every year from a VCS Doctor. A frame, when required, may tor's office, a list of all current Participating Doctors, be supplied every two years. Any variations from this, will be noted in the section on Group Contracts.

A. VISUAL SURVEY (SCREENING):

Those Patients with no specific complaints or those who indicate a desire for a routine examination should first be given a Visual Survey. If at any time during the Survey the tests indicate the need for further analysis, the Survey should be terminated and a complete Visual Analysis should be performed. If the Survey indicates no further need for professional services, the Patient should be discharged and the Doctor will be reimbursed for a Visual Survey. The Visual Survey must consist of the following and adequate records must be maintained of the results of these tests:

1. Brief history.

2. Visual Acuity at 20 feet for both eyes.

3. Visual Acuity at 15 inches for each eye and both eyes.

4. Cover test at distance and near.

5. External and internal inspection for pathology or anomalies.

6. Gross versions.

7. Pupillary reflexes.

8. Gross Retinoscopy.

If it is determined that a Visual Analysis is needed, it should be made at this point.

B. VISUAL ANALYSIS:

Any Patient with ocular symptoms or already wearing a prescriptions should be given a Complete Visual Analysis. If a Visual Analysis is deemed necessary, the Doctor will be reinbursed for it according to the schedule called for in the Contract but in no case will be reimbursed for both a Visual Survey and a Visual Analysis. The Visual Analysis will include, but not be limited to, the following:

a. Consultation and occupational analysis.

b. Visual examination

1. Case history.

2. Visual acuity; unaided, with old Rx, with new Rx.

3. Pathological investigation:

(aa) External-the eye and adnexa.

(bb) Internal-Opthalmoscopic examination of media, fundus, blood vessels, and optic nerve head.

(cc) Peripheral field of determinations.

4. Corneal curvature measurements.

5. Refractive procedure:

(aa) Retinoscopy-static and dynamic.

(bb) Phorias-distance and near, horizontal and vertical, through old Rx and new findings.

(cc) Ductions-distance and near, horizontal and vertical.

(dd) Subjective determination - distance and near.

(ee) Plus and minus to blur at near.

(ff) Amplitude of accommodation.

6. Stereopsis evaluation.

7. Color Discrimination.

c. Central fields study and/or tonometric findings for any group member over 35 years of age.

d. Analysis of all findings.

e. Professional advice and determination of Rx, if required.

f. Re-evaluation and progress examination two to six weeks after fitting of new prescription.

C. OTHER SERVICES:

Should a prescription be required, the following other services will be performed:

1. Frame selection and supplying.

2. Prescription ordering, supplying and verifying.

3. Adjustment of new spectacles and instruction on usage.

4. Subsequent servicing (refitting, re-aligning, tightening, etc.) for a period of six months.

IV. PRESCRIPTIONS

All materials must be American made and supplied and invoiced from an Approved optical laboratory. A copy of the invoice must accompany each claim request. "Payment will not be made for materials from any other source unless prior authorization is secured from the Board of Trustees of VCS." The presently approved laboratories include the following:

| | |
|---|---|
| American Optical Co. | Homer Optical Co. |
| Balester Optical Co. | New City Optical Co. |
| Bausch & Lomb, Inc. | Monumental Optical Co. |
| Hilbert Optical Co. | Trico Optical Co. |

A. LIMITATIONS

1. FRAMES:

Only American made frames may be used. The maximum frame allowance is specified in the section on Group Contracts and varies with the Contracts. If the Patient desires a more expensive frame than the maximum frame allowance, bill the maximum allowance on the Claim Form and have the Patient pay the Doctor the difference between the allowance and the actual lab cost.

The Patient must be told in advance if any extra charge is required and, on all Contracts with Fund Administration, Inc. as the Administrator, extra charge must be entered on the Claim Form. Goggle size frames which require oversize lenses are not authorized.

2. LENSES:

Only first quality, corrected curve, white or Pink #1 or 2 may be supplied. Cosmetic tints or coatings, photogray lenses, oversize lenses or any lenses requiring special thickness, base curve, seg style or power are not authorized. If clinical reasons necessitate using such lenses, prior authorization is required,

B. SPECIFIC EXCLUSIONS:

Sunglasses are not authorized. Should a specific Group Contract provide for sunglasses, the Claim Form will so state. The following are also not authorized and require prior

authorization: telescopic, microscopic and pinhole spectacles, ptosis crutches, prosthetic eyes, multifocal cataract lenses, factory order lenses, prism segments, contact lenses, aniseikonic studies and prescriptions, visual training, reading training, color field studies, dark adaptation studies, and special reports (except under Contract #639).

C. PRIOR AUTHORIZATION REQUESTS:

A "Special Claim Request Form" (SCR) may be obtained from the Administrator's office. This form must be completed, giving nature of request, clinical reasons for need, cost of materials, fees requested (if a special complex case), and prognosis of results. The form is to be returned to the Administrator and will be reviewed by the Board of Trustees. If time is a problem, the Administrator can consult with the area Peer Review Trustee for expeditious approval. The Doctor will be notified of the approval or denial of authorization. The actual authorization must be received by the Doctor prior to the rendering of "Specific Exclusions" or "Special Lenses" to the Patient.

D. PATIENTS WITH OWN RX:

Patients having prescriptions from non-participating Doctors may not be filled by Participating Doctors unless a Visual Survey is performed to determine if prescribed Rx adequately fills the need of the Patient. If the Doctor finds that the tests indicate that a change may be needed, a complete Visual Analysis is to be

performed.

V. FEES

The fees entered on the Claim Form must be no more than your usual and customary fees to other Patients. All fees for non-authorized materials and services must be according to the amount specifically authorized on the "Special Claim Request Form" by the Board of Trustees of VCS. An amount equal to 20% of the Professional Fees is retained from all claims, except Part-Time Retail Clerks or for services performed under the VIA Reciprocal Agreement, by VCS to serve as a reserve fund for the possible contingency of poor experience on claims utilization. In most cases this retention is not utilized and is returned to the Doctor at the termination of the Contract under which the claim is paid. The maximum fees vary with the Contracts and will be enumerated in the section on Group Contracts.

VI. SUPPLEMENTAL SERVICES

The Doctor will consider the payment by VCS as payment in full for all authorized services and will not bill the Patient for any part thereof. All services and materials requested by the Patient but not authorized must be explained prior to the actual rendering of such services and must not exceed the actual laboratory cost of materials used plus the following fee schedule for services performed:

A. ADDITIONAL GLASSES:

(Including sun, safety or conventional lenses and frames and all services pertaining thereto.)

1. Single Vision Rx, complete-- $10.00

2. Multifocal Rx, complete----- $13.50

B. LENSES ONLY:

1. Single Vision, each--------- $ 2.00

2. Multifocal, each------------ $ 3.75

C. FRAMES ONLY:

1. Complete frame, including selection------------------- $ 6.00
   (Fund Admin. Contracts) $ 7.00
   (Carday Contracts)
2. Front Only------------------ $ 4.00

3. Temples, each--------------- $ 1.00

Frames ordered when lenses only are authorized (every other year) may be charged to the Patient at lab cost only. No additional service fee is justified since the Material Service Fee covers this service.

D. Hinges and Miscellaneous Repairs $ 1.00

VII. SUBMITTING CLAIM FORM FOR PAYMENT

Only VCS Participating Doctors and Panel Doctors of other Vision Service Corporations with an Interchange Agreement with VCS or a Reciprocal Agreement through VIA may receive payment from VCS. Payment

will usually be made by the Administrator within 30 days after receipt of the properly executed Claim Form. To avoid delay the following must be observed:

A. Services must be performed prior to the expiration date on the Claim Form.

B. Person receiving services must be the person indicated on the Claim Form.

C. Claim must be submitted to Administrator within 90 days from the date the services are performed.

D. All services and materials must be authorized.

E. A valid invoice from an approved laboratory must accompany any claim wherein materials are supplied.

F. Claim Form must be complete and signed by both the Patient and the Doctor.

G. Claim Form and accompanying invoice should be mailed to the address at the top of the form. There are currently two Administrators processing claims for VCS. All inquiries concerning a particular claim or participant should be directed to the Administrator's office serving the Group Contract involved. The address and phone number is at the top of the Claim Form.

## VIII. GENERAL INFORMATION

### A. QUALITY CONTROL OF SERVICES:

Each Doctor is required to render the best possible service non-discriminately to all Patients he serves. Complete records must be kept of all services performed and periodic inspection of records may be made at any time by the Board of Trustees of VCS upon adequate notice. Vision Care Services, Inc. is an must always be a quality program. Any deviation from this standard may result in removal from the panel of Participating Doctors."

### B. GRIEVANCES:

Each Doctor will abide by and comply with the decisions of the Board of Trustees of VCS after proper hearing and due consideration of any complaint, grievance or dispute filed against him with respect to his services, conduct or fees.

### C. RULES OF PRACTICE:

Each Doctor will observe and abide by, and conduct his practice in accordance with the Rules of Practice of the American Optometric Association in effect from time to time, and in accordance with the Rules of Practice of the local professional society or societies having jurisdiction in each of his office locations.

D. MEMBERSHIP IN OTHER PANELS:

Each Doctor (except those participating under Interchange or Reciprocal Agreements) represents and warrants that he is not, and will not become, a member of any other group vision care program, panel or similar organization unless specifically authorized by the Board of Trustees of VCS. However, all VCS panel members practicing in Virginia must be members of the Optometric Service Corporation of Virginia.

E. INSURANCE:

Each Doctor will provide the Secretary of VCS annually with a Certificate of Insurance stating that he is covered for a minimum of $100/300,000 of Professional Liability (Mal-practice) Insurance.

F. INQUIRIES:

For additional information concerning your participation in VCS programs, contact the Trustee representative of your area.

VISION CARE SERVICES, INC.

VCS

AREA PEER REVIEW TRUSTEES

BALTIMORE
Norman Zipper, O.D., 747-5882
CENTRAL MARYLAND
V. Eugene McCrary, O.D. (Chairman), 864-5900
WASHINGTON, D.C.
Zachary N. Ephraim, O.D., 628-6465
VIRGINIA
Evart F. Warren, O.D., 356-7757

QUARTERLY NEWSLETTER

JANUARY 1976

FROM THE PRESIDENT:

It has recently come to my attention that there have been inquiries to panel doctors regarding their servicing other programs in vision care. Unfortunately, these inquiries have not been brought to the attention of the Board and VCS was nearly precluded from bidding on a most important contract. It is imperative, for the success of our venture, that the panel doctors contact a VCS officer or Board member when they hear of possible vision care contracts.

In this last instance, because of progress in the bidding process, we will have an opportunity to bid. However, if this did not occur, we would have lost a contract dealing with nearly 10,000 people -- simply because our own doctors did not contact us. Being a member of VCS has certain responsibilities. I trust all of you will live up to them.

PARTICIPATING DOCTOR'S CONTRACT:

Each of you has a copy of your agreement with VCS and one signed by you is on file in our executive office. Please read it over, as you agreed to abide by all conditions contained in the contract. The first and extremely important condition to which your attention is called is called is quoted verbatum here:

"1. I agree to have my name placed on a list of participating doctors who are on the panel of Vision Care Services, Inc., and further agree that I shall not become and represent I am not at present, either directly or indirectly, or on behalf of others, a member of any other group vision care program, corporation (not including any professional service corporation duly organized and licensed under the laws of the state in which I practice and of which I am either a shareholder, an officer, an agent, or an employee), panel, or similar organization, during the term of this contract, unless specifically authorized by the written consent of the Board of Trustees of the Corporation."

No. 82-[redacted]767

Office - Supreme Court, U.S.
FILED
DEC 13 1982
ALEXANDER L. STEVAS,
CLERK

IN THE

# Supreme Court of the United States

OCTOBER TERM, 1982

DR. NATHANIAL F. WILLIAMS,
*Petitioner,*

v.

VISION CARE SERVICES, INC.,
*Respondent.*

## BRIEF OF VISION CARE SERVICES, INC. IN OPPOSITION TO THE PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA

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## QUESTIONS PRESENTED

1. Consistent with Section 1 of the Sherman Act, may an insurer under a contractual obligation to provide services to specified beneficiaries enter into bilateral contracts with individual doctors specifying the fees which it will pay for services rendered to the beneficiaries?

2. When an insurer is contractually required to provide ophthalmic materials to its beneficiaries and where the insurer contractually agrees to reimburse the doctor for the cost of materials dispensed, may the insurer, which has no financial interest in any supplier, require that the doctor obtain the ophthalmic materials from suppliers who agree to maintain certain quality standards?

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## BRIEF OF VISION CARE SERVICES, INC. IN OPPOSITION TO THE PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA

### STATEMENT OF THE CASE

The petition for a writ of certiorari filed by Dr. Nathanial F. Williams does not accurately set forth the vision care plan at issue. Therefore Vision Care Services, Inc. ("VCS") must do so.

The vision care plan at issue is a pre-paid group plan using a panel of doctors who are free to deal with any of the many laboratories who have agreed to meet specified quality standards.

A group is simply any public or private entity that desires to provide vision care benefits to designated beneficiaries. (AA 36, 87-88).[1] The group then enters into a contract ("the insurance plan" or "plan") with VCS whereby it obtains the desired services and materials. VCS is a not for profit member corporation duly qualified as a non-profit insurer under the laws of Maryland. (AA 39).

The benefits purchased by the group for its beneficiaries generally include an annual eye examination and prescription glasses, provided that the glasses are medically required and provided that their laboratory cost does not exceed a stated allowance. If the cost does exceed the allowance, then VCS agrees to provide the eyeglasses to the beneficiary at a price equal to the difference between the allowance and the laboratory cost.[2] (AA 36).

Optical services are actually performed by licensed optometrists and ophthalmologists ("panel doctors") who enter into contracts with VCS ("participating doctor's contract"). The participating doctor's contract does not obligate VCS to provide any panel doctor with patients, but simply obligates VCS to publish a list of panel doctors which is disseminated among the beneficiaries who decide which doctor to use. The participating doctor's contract also requries VCS to pay the panel doctor for examinations actually performed on the basis of the lesser of his usual and customary fees or an allowance established for each plan. (AA 37, 85, 94-95).

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[1] "AA" and "SA" respectively refer to the appendix and the supplementary appendix filed in the court below.

[2] The plans may also provide for other benefits. For example, if a beneficiary desires to purchase ophthalmic materials for which no reimbursement or allowance is available (i.e., a second pair of glasses), then VCS agrees to provide those ophthalmic materials to the beneficiary at a price equal to the laboratory cost plus a dispensing fee. (AA 36-37, 39).

If the doctor dispenses ophthalmic materials to the beneficiary, then VCS must pay the doctor an additional dispensing fee and reimburse him for the cost of the materials. Unless prior authorization is obtained, materials dispensed under the program must come from a laboratory approved by VCS. The approval procedure is designed to insure that the participating laboratories, *in which VCS has no financial interest*, are full service laboratories producing frames and lenses of a specified quality. (AA 37-38, 88-90). Quality materials are important to VCS because of the marketing emphasis placed on the high quality of services and materials it offers. (AA 38).

With this background in mind, the relationship between Dr. Williams and VCS can be examined. Dr. Williams was a panel doctor from 1972 until early 1977. (AA 3). During his tenure beneficiaries occasionally requested him to dispense ophthalmic materials for which no reimbursement was available from VCS. When dispensing these supplementary materials, Dr. Williams charged the beneficiary at rates which he determined. (SA 100, 132-137).

In 1976 Dr. Williams requested payment for services and materials allegedly provided to a beneficiary named Irving Rich. Payment, however, was refused because the plan administrator noted that the payment form, completed and signed by Dr. Williams, stated that the examination had taken place after Mr. Rich had died. (AA 100, SA 18, 108).

The plan administrator forwarded this information to VCS which directed its internal peer review committee to investigate. (AA 100-102). After this investigation and after Dr. Williams had responded at an evidentiary hearing, the peer review committee concluded that Dr. Williams had no satisfactory explanation as to how he had

examined and dispensed materials to a deceased beneficiary. Moreover, the investigation and hearing revealed that Dr. Williams (a) kept virtually no medical records on his VCS patients; (b) on at least one occasion dispensed to a beneficiary single vision lenses, but sought reimbursement from VCS for more expensive bifocal lenses; and (c) continually dispensed to VCS patients materials from an unapproved laboratory even though he was fully satisfied with the quality of the work performed by the approved laboratories. (SA 80, 118-119, 139-140). Subsequently, Dr. Williams was terminated as a panel doctor. (AA 102, SA 147).

Discovery in this case has substantiated these findings. For example, Dr. Williams' medical records on VCS patients typically did not include such basic information as the patient's age, occupation, complaint regarding vision, nature or results of any tests performed, previous prescription, acuity without glasses, acuity under an existing prescription, or acuity under any new prescription. (SA 68-98). Dr. Williams conceded that good medical practices as well as his participating doctor's contract required him to keep such records. (SA 67-69, 73).

Dr. Williams also conceded that during the year immediately prior to his termination he was using unapproved laboratories to provide ophthalmic materials to at least 75% of his VCS patients. (SA 28-29). This was not done out of any dissatisfaction with the quality of materials or service received from approved laboratories nor out of any unwillingness of the approved laboratories to ship materials to Dr. Williams. (SA 26-28). Precisely why Dr. Williams chose to use the unapproved laboratories remains to be litigated.[3] The unapproved laboratory

[3] In its counterclaim VCS asserted that Dr. Williams' fabrication of these invoices was simply an artifice to obtain money fraudulently from VCS by seeking reimbursement from VCS for an amount greater than the actual laboratory costs that VCS

used by Dr. Williams never applied for approved status even though such status was routinely granted laboratories meeting certain industry quality standards and Dr. Williams requested that the laboratory make such an application. (AS 90, SA 78-79).

Upon the completion of discovery, VCS filed its motion for summary judgment which pursuant to the local rules of the District of Columbia included a separate pleading outlining the material facts which were not in dispute. (AA 39-42). Although Dr. Williams was granted several extensions of time within which to file a response, no formal response ever appeared on the trial court's docket. (AA 1-3). While he was proceeding *pro se*, Dr. Williams did deliver to the chambers of the trial judge a document setting forth his position with respect to the motion. Although this document (AA 44-47) was apparently not filed with the clerk of the trial court, the trial judge did consider it and heard argument from Dr. Williams' present attorney at a hearing on the motion for summary judgment. Finding no dispute as to any material fact and finding VCS was entitled to judgment as a matter of law, the trial court granted the motion and was subsequently upheld by the Court of Appeals.

## SUMMARY OF REASONS FOR DENYING THE PETITION

The writ of certiorari is a vehicle by which this Court has decided those questions of law about which the federal courts are in disagreement or even when in agreement have overlooked some fundamental precept of law. Measured against those standards, the petition should be denied.

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promised to pay any panel doctor. Because his appeal was prosecuted pursuant to a F.R. Civ. P. 54(b) certification, the counterclaim has not been adjudicated.

In recent decisions, this Court has considered and defined when insurance companies are engaged in the business of insurance and are thereby exempt from the antitrust laws. Left to the lower courts, however, has been the question of whether the antitrust laws are violated by any particular bilateral contract between an insurer and a supplier of services or materials. In considering the questions left to them by this Court the lower courts have universally held that contracts such as those at issue violate neither § 1 of the Sherman Act nor § 3 of the Clayton Act.

It is not the decisions of these lower courts, but the petitioner's position in this litigation which overlooks a fundamental precept of the antitrust laws. A contractual agreement between a buyer and a seller fixing the price to be paid by the buyer does not come within the scope of the prohibition against price fixing even where the buyer is not the beneficiary.

## ARGUMENT

### I.

**CONSISTENT WITH SECTION 1 OF THE SHERMAN ACT, AN INSURER UNDER A CONTRACTUAL OBLIGATION TO PROVIDE SERVICES TO SPECIFIED BENEFICIARIES MAY ENTER INTO BILATERAL CONTRACTS WITH INDIVIDUAL DOCTORS SPECIFYING THE FEES WHICH THE INSURER WILL PAY FOR SERVICES RENDERED TO THE BENEFICIARIES.**

The insurance plan basically provides that in return for a specified premium paid by the group, VCS will provide certain ophthalmic services to the beneficiary without charge or cost to that beneficiary. This plan differs from the typical health insurance policy only in that the insurer instead of agreeing to pay for required ophthalmic services simply agrees to provide the services. By executing a participating doctor's contract, a panel doctor such as Dr.

Williams agrees to provide those services in return for a specified payment from VCS.[4] Contrary to Dr. Williams' suggestion, neither this Court nor any other court has held that the antitrust laws are violated by such a bilateral agreement between a provider of services and an insurer obligated to provide beneficiaries with those services.

Two recent decisions of this Court, however, have referred to the question without deciding it. In *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), the precise question at issue was whether an agreement between an insurer and a pharmacy implementing prescription drug benefits for the insurer's policy holders was exempt from the antitrust laws as the business of insurance under the McCarren-Ferguson Act (15 U.S.C. § 1012(b)). The defendant offered insurance policies which entitled beneficiaries to obtain prescription drugs. If the pharmacy used by the beneficiary had executed a pharmacy agreement with the insurer, the beneficiary was required to pay only two dollars for every prescription drug with the remainder being paid directly by the insurer to the participating pharmacy. This Court was careful to note that, "Whether the agreements are *illegal* under the antitrust laws is an entirely separate question, not now before us." *Id.* at 210, n.5 (Emphasis in the original). It was also noted by this Court that the United States in its amicus brief took the position that the agreements "probably do not violate the antitrust laws." *Id.*

[4] In his petition Dr. Williams asserts that because 20% of all doctors' fees are withheld by VCS to fund possible shortfalls in any plan, the doctors rather than VCS bear the ultimate economic risk of any insurance plan. While the doctors may share in this risk, it is VCS which bears the unlimited and ultimate risk of this insurance plan.

In *Arizona v. Maricopa County Medical Society*, ___ U.S. ___, 50 U.S.L.W. 4687 (1982), this Court considered the question of whether it was illegal for two medical societies to establish fee schedules that their member doctors would accept as full payment for health services provided to policy holders of specified insurance plans. Significantly, the defendant medical societies were not insurers under an obligation to pay the doctor for services rendered to policy holders. In a four to three decision this Court held that the foundations were engaging in maximum price fixing, but again carefully circumscribed the scope of its decision.

> "Nor does this case present the question whether an insurer may, consistent with the Sherman Act, fix the fee schedule and enter into bilateral contracts with individual doctors. That question was not reached in *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979) *See, Id.* at 210, n.5. In an *amicus curiae* brief, the Department of Justice expressed its opinion that such an arrangement would be legal unless the plaintiffs could establish that a conspiracy among providers was at work . . . Our point is simply that the record provides no factual basis for the [medical society's] claim that the doctors must fix the fee schedule." *Id.* at _____, n.26, 50 U.S.L.W. at 4692, n.26.

While this Court has not directly ruled on the question at hand, numerous lower courts have reached that conclusion that such bilateral agreements between an insurer and a provider do not run afoul of the antitrust laws even where the beneficiary is obligated to pay a portion of the purchase price to the provider. *See, e.g., Sausalito Pharmacy, Inc. v. Blue Shield of California, Inc.*, 677 F.2d 47 (9th Cir.), *cer. den.* ___ U.S. ___, 43 ATRR 929 (1982); *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc.*, 675 F.2d 502 (2nd Cir. 1982); *Quality Auto Body, Inc. v. Allstate Insurance Company*, 660 F.2d 1195 (7th Cir. 1981), *cert. den.* _____ U.S. ____, 72 L. Ed. 2d 138 (1982); *Webster County Memorial Hospital v.*

*United Mine Workers of America Welfare and Retirement Fund of 1950*, 536 F.2d 419 (D.C. Cir. 1976); *Blue Cross & Blue Shield v. Michigan Ass'n. of Psychotherapy Clinics*, 1980-2 Trade Cases ¶63,351 (E.D. Mich. 1980). Indeed, even where the insurer possessed considerable market power as evidenced by its providing hospitalization insurance for 51% of the population in the market area and by its accounting for 62% of all patient days covered by commercial insurance, bilateral arrangements between the insurer and the provider specifying the fee to be paid have been upheld. *Traveler's Ins. Co. v. Blue Cross of Western Pennsylvania*, 481 F 2d 80 (3rd Cir.), *cert. den.* 414 U.S. 1093 (1973).

Thus, the holding of the trial court and the United States Court of Appeals for the District of Columbia that this bilateral arrangement between VCS and its panel doctors does not violate the antitrust laws is fully supported by the applicable case law. Indeed, given that this insurance plan obligates the insurer to provide services and materials rather than simply paying for the cost of those services and materials, there is even greater reason for holding that the bilateral contracts between VCS and panel doctors do not violate the antitrust laws.

## II.

**WHERE AN INSURER IS CONTRACTUALLY REQUIRED TO PROVIDE OPHTHALMIC MATERIALS TO ITS BENEFICIARIES AND WHERE THE INSURER CONTRACTUALLY AGREES TO REIMBURSE THE DOCTOR FOR THE COST OF THE MATERIALS TO BE DISPENSED, THE INSURER, WHICH HAS NO FINANCIAL INTEREST IN ANY LABORATORY, MAY REQUIRE THAT THE DOCTOR OBTAIN THE OPHTHALMIC MATERIALS FROM SUPPLIERS WHO AGREE TO MAINTAIN CERTAIN QUALITY STANDARDS.**

Whether VCS, which has no laboratories nor any financial interest in any laboratory, may justifiably require ophthalmic goods purchased for its account be from designated sources of supply without violating § 3 of the

Clayton Act (15 U.S.C. § 14) is an issue which has long been settled. In his attempt to show otherwise, Dr. Williams simply failed to prove any of the elements of a violation of § 3 of the Clayton Act.

The first element in a Clayton § 3 case is that the contract at issue be one involving a lease or sale of goods as opposed to the purchase of services. *See, e.g., Advance Systems and Supply Co. v. SCM Corp.*, 415 F.2d 55 (4th Cir. 1969), *cert. den.* 397 U.S. 920 (1970). The contract between Dr. Williams and VCS, however, is simply one whereby VCS purchases services from Dr. Williams. While Dr. Williams may purchase materials for VCS's account, he does not sell any goods to VCS.

In a Clayton § 3 case it is also incumbent upon the plaintiff to prove that the sale at issue is one whereby the seller through the vehicle of an exclusive dealing arrangement is attempting to preclude the buyer from buying or leasing the goods of its competitor. The seller and the precluded supplier must be competitors. *See, e.g., Elliott & Frantz, Inc. v. Raygo, Inc.*, 379 F. Supp. 498 (E.D. Pa. 1974). In this case the allegedly precluded suppliers, the non-approved laboratories, are not competitors of VCS because VCS neither owns a laboratory nor does it have any financial interest in any laboratory.

Finally, in a Clayton § 3 case it is necessary for the plaintiff to prove that that the effect of the agreement is either to "substantially lessen competition or tend to create a monopoly in any line of commerce." *See, e.g., Pitchford v. Pepi, Inc.*, 531 F.2d 93 (3rd Cir. 1975). *cert. den.* 426 U.S. 935 (1976). Dr. Williams did not produce any economic data suggesting how competition was affected by the alleged exclusive dealing arrangement nor did he produce any proof that any competitor was actually precluded from selling its goods to VCS. The evidence affirmatively demonstrates that the opportunities for any

laboratory to enter the program are not limited because any laboratory desiring to sell goods to VCS simply has to make an application to VCS so that it may determine that quality standards will be upheld. There is no evidence that the quality standards were arbitrarily applied, but instead all of the evidence simply demonstrates that many laboratories could and did meet the approved quality standards. It is, of course, unknown whether the unapproved laboratory which Dr. Williams chose to use did meet these specified quality standards for the simple reason that that laboratory chose not to make an application.

## CONCLUSION

No compelling reason exists for this Court to exercise its jurisdiction by granting petitioner's writ of certiorari. There is no conflict among the circuits on this issue and the factual record before this Court discloses no reason why this particular bilateral agreement between an insurer and a supplier of services violates the antitrust laws.

Respectfully submitted,

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No. 82-767

In The

SUPREME COURT OF THE UNITED STATES

October Term, 1982

DR. NATHANIAL F. WILLIAMS,
Petitioner,

v.

VISION CARE SERVICES, INC.,
Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA

# REPLY BRIEF OF DR. NATHANIEL L. WILLIAMS

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# REPLY BRIEF OF DR. NATHANIAL F. WILLIAMS

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## I. VISION OF CARE SERVICES, INC. CHARACTERIZES ITSELF AS "AN INSURER."

In reading its arguments in its brief in opposition to the petition for a writ of certiorari, Vision Care Services, Inc. has characterized itself as an insurer. Such a characterization of itself by Vision Care Services, Inc. is irrelevant to this case. The restraints involved in this case are not restraints between Vision Care Services, Inc. and persons who are insured by Vision Care

Services, Inc. These are separate contractual agreements between Vision Care Services, Inc. and panel doctors engaged in the sale and distribution of goods and services other other than insurance. Thus, the arrangement in this case is virtually identical to that which existed in Group Life and Health Insurance Company v. Royal Drug Company, 440 U.S. 205 (1979). In the Group Life case, Blue Shield, a recognized insurance company, "offered "offered to enter into a Pharmacy Agreement with each licensed pharmacy in Texas. Under the agreement, a participating pharmacy agrees to furnish prescription drugs to Blue Shield's policyholders at $2.00 for each prescription, and Blue Shield agrees to reimburse the pharmacy for the pharmacy's cost of acquiring the amount of the drug prescribed." The Group Life case presented this court with the question of whether the contracts between Blue Shield and the pharmacies constituted the "business of insurance." Group Life at

209. And thereby excepted Blue Shield from the Antitrust Laws under section 2(b) of the McCarran-Ferguson Act. Group Life at 210. This court held that the activities involved were not insurance activities and therefore not exempt. This court pointed out that "[i]nstead of a total exemption, Congress provided in section 2(b) that the antitrust laws 'shall be applicable' unless the activities of insurance companies are the business business of insurance and regulated by state law." Group Life at 219. In Group Life case the District had granted summary judgment to the defendant and the court of appeals reversed. This court sustained the decision of the court of appeals. Therefore, the case was remanded to the trial court for a determination on the antitrust issues.

In the case presently before this court, the activities between Vision Care Services, Inc. and the doctors are not "the business of insurance." Thus, this case, like the Group

Life case, should not have been dismissed on summary judgment, but there should be a trial on the antitrust issues.

## II. VISION CARE SERVICES, INC. DISAGREES WITH THE PETITIONERS DESCRIPTION OF THE VISION CARE PLAN.

While Vision Care Services asserts in its brief that the petitioner "does not accurately set forth the Vision Care Plan at issue. It in no manner anywhere in its brief states in any portions of the petitioner's description that Vision Care Services regards as inaccurate. Vision Care Services merely tries to divert attention to some of the less controversal aspects of its plan. The arrangements in question in this case clearly involve more than an "insurer" providing goods and services to its "insureds" or a quality on sources of supply.

On page seven of its brief Vision Care Services attempts to give the impression that its contracts merely set the amount that Vision

Care Services is willing to pay the panel doctors. This is cearly not the situation. The Vision Care Service contract restricts the participating panal doctors from charging more than the amount established by Vision Care Services without regard to who is to pay the amount. This fact is clearly set forth in Paragraph VI of the Vision Care Services contract. In that paragraph which is entitled "Supplemental Services" the contract provides, "The Doctor will consider the payment by Vision Care Services as payment in full for all authorized services and will not bill the patient for any part thereof." Thus, the price fixing extends beyond the point to which Vision Care Services would have to pay.

In the same paragraph Vision Care Services has another price restraint. It restricts the amount that may be charged for services and materials which are not authorized by the Vision Care Services plan. In other words, Vision Care sets a price ceiling

patient himself is responsible for paying the entire amount. The contract provides that the amount that the doctor may charge in these instances "must not exceed the actual laboratory cost of materials used plus the following fee schedule for services performed." The Vision Care Services contract then sets forth the fixed fee schedule.

III. VISION CARE SERVICES, INC. AGRUES THAT ITS RESTRICTIONS ON THE DOCTORS' SOURCES OF SUPPLIES WERE "TO MAINTAIN CERTAIN QUALITY STANDARDS."

The quality control contention is not supportable by anything in the pleadings or in the record. Since the inquiry letter which Vision Care Services sends out ask only about the prices charged, it appears that the price that the supplier will charge the doctor for the laboratory materials is the prime, if not the sole selective factor. However, if Vision Care Services, Inc. has "certain quality standards" it should be required to show that at trial. Other factors indicating that quality

standards is the basis for the source restriction are Paragraph IV of the Vision Care Services contract which requires that "all materials must be American made and supplied," and Paragraph IV A. 1 which states that "only American made frames may be used." There is no rational relationship between the geographical place of manaufacture and the quality of the product.

## IV. VISION CARE SERVICE, INC.'S ATTACK ON DR. WILLIAMS' CHARACTER IS UNWARRANTED, MISLEADING AND IRRELEVANT TO THE ISSUES BEFORE THE COURT IN THIS CASE.

On page three of its brief, Vision Care Services, Inc. attempts to give the impression that Dr. Williams attempted to perpetrate a fraud. Such is not the case. Dr. Williams did not state that an examination had taken place after Mr. Rich had died. It is beyond question that Dr. Williams examined Mr. Rich while Mr. Rich was alive. However, Dr. Williams did not send in a request for payment for some time after the examination. Mr. Rich

died after the examination but before Dr. Williams sent in the request for payment for his services. Dr. Williams did not know Mr. Rich had died when he sent in the request for payment. When Dr. Williams sent in the request request for payment he indicated a date close to the time when the payment was requested rather than the actual date on which Mr. Rich had been examined. In short, Dr. Williams did not claim payment for examination of a person who was already dead. He simply gave a wrong date for an examination that had actually occurred.

## CONCLUSION

For the foregoing reasons the petition for a writ of certiorari in this case should be granted.

Respectfully submitted

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